THE THERAPEUTIC RELATIONSHIP IN INTEGRATIVE PSYCHOTERAPY

Vlad Brănesc[1]

[1]"Branesc" professional psychological civil association, centre of qualitative research in counselling and psychotherapy, Romania

Corresponding author: Vlad Brănesc, vlad@psiterapia.com

ABSTRACT: The way a therapeutic process unfolds is usually influenced by various factors such as the problem or possible pathology of the client, the therapist's skills to analyze and use information in order to guide the client to solve the problem, and also the relationship quality between client and therapist and the inevitable changes that occur during therapy. The hypothesis of this study is to assume that the bond created between client and therapist is the basis for therapeutic success. The objective is to present certain aspects that support the crucial role of the therapeutic relationship, emphasising the essential qualities that lead to positive therapeutic outcomes. Knowing the core components of a therapeutic relationship allows repair of possible ruptures in the therapeutic alliance.
KEYWORDS: therapeutic alliance, integrative strategic psychotherapy, trust, therapeutic relationship

1. INTRODUCTION. INTEGRATIVE THEORETICAL PERSPECTIVES ON THERAPEUTIC RELATIONSHIP

Published works in psychotherapy show that the terms "therapeutic relationship" and "therapeutic alliance" are often used in various contexts. Therapeutic alliance is mentioned in Freud's theories about transfer (Freud, 2010), Freud changing his initial negative outlook on transfer into a different one that considers the possibility of an attachment between therapist and client as a beneficial attachment and not just as a projection.

In 1956, Elizabeth Zetzel-Rosenberg expands the description of therapeutic alliance considering it a relational component that exists between patient and therapist; not a transferential or neurotic relation, but one that gives patients the chance to observe the therapist and to understand and use his interpretations. Therefore, the therapeutic relationship can be considered an alliance or cooperation between the two parties, based on reality.

According to data presented, it can be observed that the principle of the therapeutic relationship has always had a tendency to grow together with the development of psychotherapeutic theories, so there is a need to review and integrate some classical concepts with modern ones which can better represent the current clinical situation.

Thus the objective of this paper has been to corroborate the theoretical perspectives related to the concept of the therapeutic relationship and to link them with the fundamentals of the Integrative Strategic Model of the Self.

The study has started from the hypothesis that therapeutic relationship is by definition a dynamic and ever-changing factor which depends on the therapist as an individual as well as on the methodology chosen by him in order to be used in the therapeutic process, therefore the integrative strategic psychotherapy can take over, expand and reinterpret certain issues in the therapeutic relationship in general and in therapeutic alliance in particular.

Norcross (2000) sustains that therapeutic relationship is composed of the feelings, attitudes and behaviours that the client and the therapist manifest to each other (Norcross, 2000, as cited in Smith and Vîşcu, 2016)

The basic factors for a successful therapy can be influenced by the therapeutic process, therefore maintaining a satisfactory connection is extremely important especially for pathologies that require therapy for a longer period of time (O'Brien, Houston, 2009).

Clarkson believes that psychotherapy includes in fact many types of relationships, such as the employment relationship, the transference and counter-transference relationship, the development relationship and the person-to-person relationship (Clarkson, 2003, as cited in Dryden, 2010). In spite of that, Kahn describes the relationship as being singular and the therapist being present, active and also involved (Kahn, 1997, as cited in Dryden, 2010).

Studies regarding the importance of the therapeutic relationship have led to the hypothesis that this connection between client and therapist may be due simply to the development of the therapy, in which case the success of the therapeutic process may be caused by solving the alliance ruptures rather than by a model consisting of a linear increase.

However, the "time" factor is not necessarily the most important; research shows that therapeutic results revealed in the start phase and in the end phase have an increased predictability compared to results from the middle stage of the therapy (Horvath and Symonds, 1991).

Having discovered this valuable information leads researchers to the establishment of two significant stages of the therapeutic relationship:

- the creation and initial development of the alliance during the first sessions, consisting of encouraging cooperation by increasing the trust level, and also by agreeing over the objectives and techniques used;
- the "attack" on dysfunctional thoughts that actually induces the client's problem, with the objective of transforming the behavioural patterns, action which could be interpreted in a negative manner by the client or as lack of support and understanding from the therapist. This is the reason why the therapist must show an increased attention to the way his client perceives the situation.

Consequently, it can be said that a therapeutic relationship actually takes place on different levels: the first level locates the core of the therapeutic change in the link between the internal experience felt by the client and the symbols, his feelings representing the source, place and decision on accomplishing cognitive and behavioural changes.

The second level includes the relationship between the client and his inner state: any individual can activate his own therapeutic process outside of therapy or between meetings, part of the "healing" being accomplished without the help of the therapist.

According to Popescu and Vîşcu, the most important aspects of this relationship refer to the ability and willingness of the client to overcome barriers and to communicate with the therapist, also to the reason he came to therapy, his goals, the levels of motivation and manifestation of the disorder or problem, his perception on people, on the world and life itself, his previous experiences and also non-compliance (Popescu and Vîşcu, 2016).

2. THE RELATIONSHIP BETWEEN THERAPIST AND CLIENT, SEEN AS A BASIS FOR A SUCCESFUL THERAPY

One of the necessary conditions for developing a stable therapeutic process is represented by the client's confidence in the therapist's capability of helping him and also by the therapist's confidence in the client's resources (Bordin, 1970, as cited in Horvath and Luborsky, 1993). O'Brien and Houston (2009) have had a similar theory stating that the aptitudes, competences and emotions of the therapist are significant factors in creating and maintaining the therapeutic process.

As a result, it can be stated that the quality of the relationship is very important for the therapeutic result because an adequate relationship is able to increase the acceptance and belief in the established treatment, therefore proving the interdependence between the therapeutic process and the chosen intervention procedures (Horvath and Luborsky, 1993).

O'Brien and Houston believe that an efficient therapist has to move his attention from the instrumental aspects to the fact of being there for the client (Gestalt therapy approach), observing his thoughts, feelings and behaviour in the present context (O'Brien and Houston, 2009).

Person-Centred Therapy describes the two components, the therapist's qualities and the therapeutic relationship, as the most powerful tools for boosting the client's personal development. Thus, it is obvious that the therapist can be a positive role model for his clients especially when he manages to create a healthy therapeutic relationship with them. Seligman notes that the therapist must develop self-awareness and a positive attitude, a good ability to understand people, and also honesty and authenticity (Seligman, 2001). An important aspect is that the therapist's attitude and trust in the client's internal resources contribute to the development of an appropriate therapeutic environment (Corey, 2005). Nelson-Jones points out that people naturally have the need for a sense of belonging, which is why they engage in social relationships, but the essential condition for reciprocity consists of accepting each other's needs and uniqueness (Nelson-Jones, 2000).

Kottler and Brown describe Rogers' faith in the therapeutic power of a relationship based on trust, openness, acceptance, permissibility and at the same time, warmth, qualities that lead to the desired changes in the client's attitude and behaviour (Kottler & Brown, 2000).

According to Rogers, the most important components of the therapeutic relationship are empathy, congruence and an unconditional positive attitude, which he sees as basic aspects of the Person-Centred Therapy. The therapist also needs to be honest, open and authentic, summarizing and highlighting the client's experiences of great importance for the therapeutic process (Rogers, 1951, as cited in Grossmann, 2011).

Among the qualities necessary for a therapist there is also maturity, competence and the ability to maintain a good mental health. Furthermore, it is essential for

the therapist to pursue his own personal growth and to be a role model for the client, Rogers believing that in this way a therapist would influence the client's motivation to improve his abilities.

Thus, a therapist who maintains a positive attitude towards himself and others, towards life and the world, should be more open and mentally healthy, and by communicating this attitude to his clients he should induce the creation of a positive environment which is more likely to reduce resistance.

Being this type of therapist can also influence clients to become more open, allowing them to experience self-understanding and self-directing as change factors, as well as to discover their own potential and to continue their personal development.

Starting with the idea that each individual is unique, that nobody feels, perceives or thinks exactly the same, it is easier for the therapist to become aware of his own uniqueness and to understand the client's qualities and beliefs in order to accept them and to shape them. The personal message often has the power to persuade others and to motivate them to become better, to want to evolve, to make a change and to accept the opportunities that life has to offer (Corey, 2005).

Rogers considers congruence as an important part of the therapeutic relationship, together with empathy which is useful when approaching anxious and vulnerable individuals, thus leading to reduced defence mechanisms (Nelson-Jones, 2000). Brown and Kottler support this idea, adding that the therapist needs to develop its own congruence regarding his feelings and the things he manifests on the outside (Kottler & Brown, 2000). Confidentiality and consent are the basis of creating trust regarding the therapist and the process itself, but there are some exceptional cases that violate this privacy, such as producing a deliberate harm, respecting a court order, also in case of abuse or if a minor is the victim of incest or rape, etc. (Corey, 2005).

According to this author, consent done knowingly also involves honesty and respect, the client having the right to take decisions. Confidentiality and informed consent are viewed by him as an additional factor that induces safety and trust, helping clients to disclose their problems.

Informed consent represents an ethical and legal requirement that supports respecting the individual's dignity, and is connected with the objectives settled during therapy, with the therapist's responsibilities towards his client and also with the client's responsibilities, with the limits and exceptions regarding confidentiality, with various legal and ethical issues, with the therapist's qualification, with costs and therapy's extent over time, advantages and associated risks, and also with discussing the client's problem with the therapist's colleagues or supervisors if needed (Corey, 2005).

According to Conrad, therapeutic alliance has the role of creating a change in the client's life after his interaction with the therapist (Conrad, 1952, as cited in Popescu and Vîșcu, 2016). O'Brien and Houston state that working alliance can be seen as a bridge between being there for the client and doing something together with the client in order to achieve the objectives set (O'Brien and Houston, 2009). Bordin emphasizes the client and therapist collaboration which he sees necessary for the process of overcoming the client's distress and self-destructive behaviour.

Thus, the therapeutic alliance is thought to be composed of three parts: the first one actually represents an understanding of the objectives pursued, the second refers to the established working tasks, and the third includes creating a personal connection based on positive mutual feelings, all of these helping to create an ideal relationship based on the therapist's and client's common beliefs regarding the goal of the therapy (Bordin, 1970, as cited in Horvath and Luborski, 1993).

In the process of becoming a therapist, one learns from experience how to obtain certain dexterity to overcome this paradox. It is a process where, unlike ordinary life, the emotional responses are inhibited, but not the affective perception, this leading to learning how to internalize emotional responses so they can be placed in the service of therapy. If the process fails, the professional ego is unbalanced.

There is also a terminology for this imbalance, through the phenomenon known as "projective identification". This phenomenon has been defined in various ways; the most used perspective regarding the process by which the client's specific affective elements are communicated unconsciously to the therapist. Therapists in turn, may not recognize that what they are facing is primary originated in the client's mind and not in theirs. Therefore, projective identifications, if any, are not recognized as such by the therapist and can have a disturbing influence upon them. Sometimes the client communicates through actions that induce to the therapist the exact same emotional response that the client has had as a child. In other cases, it isn't clear through what means the emotional experience of the client is somehow "placed" inside the therapist.

This uncertainty has led some observers to consider projective identification as an occult phenomenon or a mystic process. Many think it is like a vestige

remained in the adult individual from a preverbal or paraverbal form of communication that has been developed between mother and child.

The main therapeutic approaches, such as integrative therapy, cognitive-behavioural therapy, emotion-focused therapy, Gestalt therapy, experiential therapy, psycho-dynamic and relational models, consider the alliance as a positive affective link between client and therapist, consisting of collaboration on tasks and goals of the therapy (Bordin, 1979).

Therefore, establishing an agreement concerning these objectives turns the therapeutic process into a special collaboration called "working alliance". Bordin also defines tasks in therapy as specific activities from different approaches having a therapeutic purpose: for example, the technique of free association in psychoanalysis, the homework used in cognitive-behavioural therapy or the "empty chair" technique used in Gestalt therapy (Bordin, 1979).As targets of the therapeutic process, the client and the therapist may seek to obtain a lower level of anxiety, improved self-esteem, precise setting of the client's needs and meaning of life. The existence of a collaboration regarding therapeutic tasks and objectives may lead to consolidating the therapeutic alliance, the same way as the emergence of a failure in creating the agreement between the two sides can lead to an imbalance (Bambling, King, 2001).

However, there have been only a few studies made on the connection between therapeutic alliance and the way it manifests in group psychotherapy. Unlike individual therapy where there is only the therapist-client dyad, when expanding a multidimensional construct to a group of people, the result is having more therapeutic agents: the therapist, or therapists, because there are two in most cases, then the group members and the group taken as a whole.

Consequently, there are more levels on the established relationships inside the group, this resulting in several types of alliance: the individual alliance between client and therapist, the alliance between members, the alliance with therapists across the whole group and finally the group considered as a whole.

Besides these issues that have been discussed, another relevant concept for group psychotherapy is the "cohesion", often equated with the term "alliance". To clarify this situation, Yalom (1995) mentions together with the idea of cohesion also a sense of confidence and support regarding the group, which reveals the idea of engagement around common themes and ultimately leads to increasing respect for oneself, reducing the symptoms.

When speaking about alliance, it is important to know that contracting is based more on the idea of a conscious and rational agreement which is useful in creating the alliance. Some authors sustain that this idea includes underestimating the importance of unconscious factors in the participation of the two parties involved in the therapeutic relationship, although this unconscious participation of the therapist in negotiating the alliance is inevitable (Safran & Muran, 2000).

As a conclusion, negotiation involves both emotional and transferential components, using the conscious as well as the unconscious side, because the alliance isn't based on a strictly rational agreement. Safran and Muran write that negotiation highlights the transformation of goals and objectives during therapy (Safran & Muran, 2000). Although most studies speak about relational and technical separation factors, the constructivist view sustains that any task can be understood only in the relational context to which it applies (Safran & Muran, 2006).

Usefulness of therapeutic interventions, according to Muran, is often mediated by how these affect the relationship, any attempt to remove the technical and the relational side being difficult to realise other than statistically (Safran & Muran, 2006). Therefore, it would be necessary to include a hermeneutical direction in order to discover and analyze the meanings assigned by the client to the methods used in therapy.

3. THE VALUE OF REPAIRING A RUPTURE IN THE THERAPEUTIC ALLIANCE

According to Safran and Muran (2006), the concept of negotiating the therapeutic alliance involves a process that extends over time. Regarding the temporal context of the client-therapist relationship, there are two therapeutic groups: one that includes short-term changes of the therapeutic relationship and the other showing the global dynamics related to the development of this relationship. For example, it may be composed of a phase characterized by a well-established relationship, which then goes through a stage of decline and is rebuilt afterwards (Horvath, Luborsky, 1993).

The study made by Kivlighan and Shaughnessy describes three essential stages in developing the alliance between client and therapist: the first consists of a stable alliance with only small changes from one meeting to another, the second is characterized by a linear increase (the alliance gets stronger) and the third can be represented as a "U"-shaped model (the alliance is strong, then weak and then strong again)

which has actually showed the best results over the first meetings (Kivlighan and Shaughnessy, 2000).

Taking into account the opinion of these authors, the relationship established between the two sides may change in certain moments of the therapeutic process due to various reasons.

Therefore, the quality of the therapeutic relationship can be considered an extremely important variable, with a high predictability of success, regardless of the type of therapy used. Besides the three models, Stevens and his colleagues have discovered a fourth, a "V"-shaped model, characterized by the emergence of more alliance ruptures and repairs during the middle sessions (Stevens et al, 2007).

Published works usually define therapeutic alliance as a framework that facilitates the therapeutic activity, but which is not necessarily therapeutic itself (Safran & Muran, 2000). Research carried out about alliance ruptures indicates they are an almost inevitable aspect of the therapeutic process, but the alliance recovery leads to positive therapeutic outcomes by strengthening the connection between client and therapist.

Popescu and Vîşcu list the following reasons for these ruptures that can occur within the alliance: the therapist is critical or unsupportive, non-directive or cautious, he changes techniques too often, becomes too subjective, gives a wrong diagnosis, has difficulties in managing the issues related to transference or countertransference (Popescu and Vîşcu, 2016).

It is said that the progress of therapy involves developing a dynamic alliance with a series of sequences consisting of ruptures and repairs that are designed to strengthen the relationship. It is also theorized that this sequence of rupture-repair is therapeutic for the following reasons: it is necessary for the therapist to empathically fail in adjusting with the client in order to simulate failures in the client's important relationships, and repairing these ruptures helps to gradually increase the client's capacity to control negative emotions, while becoming more aware of the maladaptive states he has experienced (Safran & Muran, 2000).Furthermore, Safran and Muran sustain that negotiating ruptures in the alliance leads to learning how clients can express their needs and affirm themselves without this damaging their relationship with the therapist, helping them to feel independent and more involved at the same time.

Therefore, it can be said that negotiating the therapeutic alliance is not only helpful for therapy, but it is also a healing factor providing an emotional or corrective experience for the client (Safran & Muran, 2000).

4. CONCLUSIONS

For most clients, the therapeutic relationship is a well-guarded sanctuary, a place where they feel safe to express love and hate that cannot be manifested freely within other contexts.

Consequently, the direct expression of love and hatred may pose certain problems for the therapist, because their image materialized in the client's response does not distinguish between ordinary life and the therapeutic context. This creates the possibility of a complementary response despite the idiosyncratic model: the client's hatred, love and, in some cases, sexual arousal, will induce some emotional responses in the therapist. For example, when confronted with the client's rage, some therapists can also feel rage, while to others it can bring anxiety.

At some level of reality, therefore, the two participants are just ordinary people, while at another level which is part of a particular asymmetric setting; it is shown a relationship that has no correspondent to everyday life. Considering the matters described above, it can be stated that the Integrative Strategic Model is a flexible way to establish an alliance according to the specific needs of each client.

A part of the people who come to therapy may require a more structured initial approach in order to understand and clarify the therapeutic tasks and objectives, while others need a collaboration based on trust and safety, relying less on structured approaches.

However, all therapeutic relationships have in common the process of signing a contract at the beginning of therapy, which contains agreed-on items regarding the therapeutic process and relationship (O'Brien & Houston, 2009). Accordingly, it can be said that this agreement on the tasks and goals of therapy facilitates both the therapeutic activity and collaboration with the client, strengthening the alliance and also the client's involvement. Although this initial contracting, together with finding the best way that leads to a collaboration between the two individuals, are vital processes for therapy, it is believed that the concept of building the alliance should focus more on a continuous negotiation of the conditions and terms throughout treatment, and the therapeutic relationship should be maintained and strengthened in each therapeutic session.

The purpose of this paper to corroborate all trans-theoretic aspects of the therapeutic relationship concept and to connect it to the Integrative Strategic Model of the Self has been successfully fulfilled,

thereby adding another brick to the foundation of integrative psychotherapy.

However, as noted throughout the study, the therapeutic relationship, the alliance and the therapist's qualities are closely correlated, and identifying specific aspects characterizing only some types of therapy is extremely difficult because any approach, whether generalized or condensed, must consider both the objective reality of the therapy and the client's subjective reality.

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